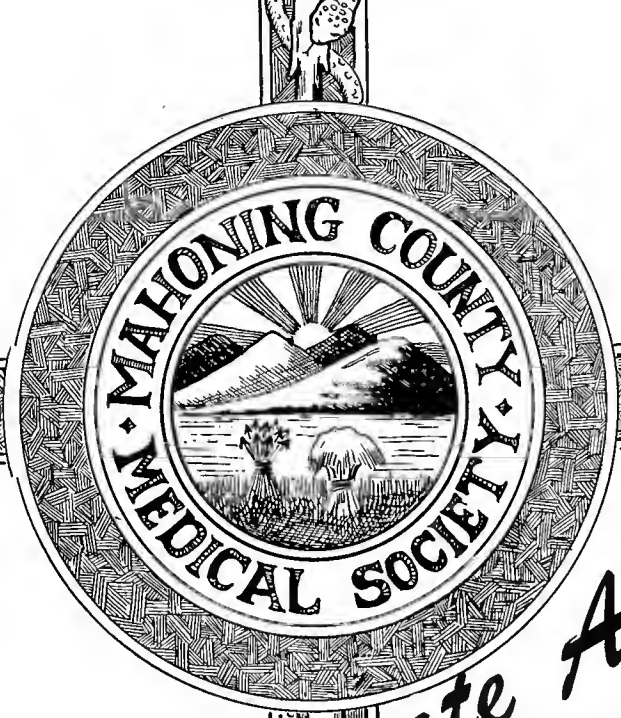

Postgraduate Assembly

WARREN, OHIO

WEDNESDAY, OCT. 21

BULLETIN

of the
MAHONING
COUNTY
MEDICAL
SOCIETY

October • 1959
Vol. XXIX • No. 10
Youngstown • Ohio

OCTOBER

SIXTH DISTRICT POSTGRADUATE ASSEMBLY

Wednesday, October 21 — Warren, Ohio

This is one of the best Postgraduate Assemblies in the country. Plan to attend. See the complete program on the center spread of this issue of the Bulletin.

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G. A. Sudimack, M.D.
342 Oak Knoll, N.E.
Warren, Ohio

●

OCTOBER MEETING

Tuesday, October 13, Elks Club

A special business meeting has been called to present the revised constitution of the Medical Society. This is important business, requiring the attendance of every member.

●

NOVEMBER MEETING

Tuesday, November 17, Elks Club

DIABETES MEETING—NOMINATION OF OFFICERS

SPEAKER: Dr. James W. Craig, Assistant Professor of Medicine, Western Reserve University School of Medicine

OFFICERS AND COUNCIL

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F. G. SCHLECHT, Pres.-Elect 2218 Market Street
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A. K. PHILLIPS, Secy. 1005 Belmont Avenue
C. W. STERTZBACH, Treas. 3610 Market Street
L. O. GREGG, Editor Dollar Bank Building

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H. J. REESE	F. A. RESCH	A. RANDELL (1962)	S. W. ONDASH

Representative to the Associated Hospital Service: J. M. RANZ

Executive Secretary: H. C. REMPES, JR.

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Our President Speaks

Election time is approaching locally. I hope we are all qualified to vote in November, for many a good man was defeated by the good citizens who did not vote. As a good citizen you have a duty and a right to vote and support candidates who will help protect your interests. You can do it by voting and giving financial support to those who are for free choice of patient-physician relationship. Please vote and participate actively.

Many thanks to a gracious gentleman who has done a wonderful job for our society, Dr. McGregor, Chairman of the County Fair Committee.

Mr. Sid Davis of W.K.B.N. News Director, has left us. We regret his leaving Youngstown. He was a real friend of the doctors and extended himself to bring accurate information about doctors to the public. Best wishes in his new job.

M. W. Neidus, M.D.
President

BULLETIN of the Mahoning County Medical Society

Published Monthly in Youngstown, Ohio — Annual Subscription $2.00
245 Bel-Park Bldg. — 1005 Belmont Ave. — RIverside 6-8431

Volume 29 — **October, 1959** — **Number 10**

Published for and by the Members of the Mahoning County Medical Society

EDITORAL—

ROLE OF THE GENERAL PRACTITIONER

According to a leading medical authority, there is an apparent void developing between general practitioners and hospitals which is working to the detriment of the patient.

As a result of rapid development and increasing complexity of medicine and impositions on the practice of medicine by various groups the Family Doctor has become more disassociated from hospitals and especially teaching hospitals.

Since the General Practitioner has the patients confidence and friendship, he is the best qualified to study the patients disease in all respects. There is no reason why this confidence and friendship which is so important should be disrupted. When a patient goes to a hospital he needs someone who he believes in and considers a friend, his family physician.

In the surgical field, many physicians in general practice are prevented from doing certain procedures which they are capable of doing. It does not seem justified to deprive a physician from doing procedures he can capably perform because he does not happen to be a specialist.

He could play a large part in the field of teaching in hospitals and medical schools. With his wide experience in treating all types of diseases, who is better qualified to teach medical students and interns.

With the advancement of medicine, the role of the General Practitioner becomes more complex. He has to be well trained, constantly alert and able to diagnose and treat all illnesses from all aspects. He should be a part of the hospital team and not relegated to a lesser role as he is in many hospitals.

L. O. Gregg, M.D.
Editor

EXECUTIVE SECRETARY'S REPORT

It would be difficult to judge just how far-reaching is the influence of the medical society. Sometimes we touch people directly, as, for instance, with the compulsory immunization of school children, following a resolution submitted by this and other societies in the state of Ohio. More often, the influence cannot be measured. For instance, the mere fact that a group of doctors exists, bound together by a desire to improve health and medicine, and going about the routine society business, must give medical confidence to the people of this community.

Then, once in a long while, the word comes back telling of influence from an unexpected quarter—and we experience elation.

Early last spring, we received an inquiry from Lorain County Medical Society asking about our Canfield Fair project. We passed along all the details and promptly forgot the matter.

Then, following the Fair, we received a phone call from the Executive Secretary of the Lorain County Society telling us what had happened. On the strength of the Mahoning Society successes in exhibiting at the Fair, the Lorain County Society enthusiastically plunged into their own county fair for the first time, undertaking the tremendous task of setting up fourteen exhibits (the original inquiry had been concerned with one or two exhibits) in their own tent (originally scheduled to be just a booth) and manning it with 57 physicians, almost half the membership of the society. The results were a spectacular display of medical health to the citizens of Lorain County. And we are overawed, and just a little proud, that our continuing year-in year-out routine work at the Canfield Fair should inspire such an outpouring of effort in another part of the country.

Where else is our influence felt? We can't be sure, and because we can't be sure, every member must continue to give his very best—to serve on committees, to attend meetings, to fulfill his membership in the Mahoning County Medical Society. By such routine business, we strengthen our society and our very strength becomes a strong influence for good medicine and good health.

Howard Rempes
Executive Secretary

RESOLUTION

WHEREAS, during his tenure as News Director for radio and television station, WKBN, Sid Davis earned an enviable reputation for his capable and truthful reporting of the news, thereby being of great service to his community, and

WHEREAS, he was particularly understanding of both physicians and hospitals in his reporting of medical news, and

WHEREAS, he was at all times ready and willing to aid the Mahoning County Medical Society in preparing radio and television programs, and to advise the society in the pursuit of better public relations, therefore

BE IT RESOLVED, that the council of the Mahoning County Medical Society bring to the attention of all of the members of the Society, and to the management of WKBN, the highest commendation of this Society to Sid Davis for his conscientious reporting, which served to bring about better understanding of medical affairs by the citizens of this community.

POLIOMYELITIS; COMPLICATIONS AND TREATMENT

DEFINITION: Poliomyelitis is an enteric viral disease characterized by viremia and a mild febrile illness; in certain cases a lower motor paralysis develops. The diseases is caused usually by one of three strains of virus: Brunhilde (Type 1), Lansing (Type 2) or Leon (Type 3). Brunhilde strain was so named because the primate from which the virus was isolated was a chimpanzee who sang in her cage. Hence her Wagnerian name—and a task for students of medicine for years to come; to learn another eponym.

EPIDEMIOLOGY: Fifteen years ago the manner in which the disease would be transmitted between case "A" on one side of a city and case "B" in perhaps a distant part of that city was a mystery with no apparent means of transmission. Now it is appreciated that inapparent cases are mainly responsible for transmission and the paralytic form of the disease occurs in only 1 in 100-200 persons who get polio. The vast majority get only a viremia.

It has been postulated that pregnant women are more susceptible to polio. The increased incidence of polio in pregnant women more recently has been ascribed to direct exposure which corresponds to the number of small children in the home and the female in the child-bearing years, especially the pregnant woman, is surrounded by more pre-school children than any other population group.

THE PORTAL OF ENTRY: Although the virus is harbored in sewage and carried by flies and contaminated drinking water or milk, polio is also regarded as a contact disease. The portal of entry is the mouth. It may enter the body through the lymphatic tissue in the throat or Peyer's patches and then to the blood stream. In the one unlucky individual out of a hundred destined for paralytic disease it enters the central nervous system. The epidemiology varies with population groups depending upon their acquired immunity. In South Africa, serologic evidence of post-infection immunity was found in only a few percent of Whites; among the relatively primitive Bantu natives, who were economically depressed, almost 100% of the children had acquired immunity by the time they were of school age. There, respiratory and paralytic polio in the young adults was unheard of; it was quite frequent among the whites.

The susceptible young adult may get very severe disease often accompanied by respiratory involvement. Younger susceptibles get somewhat milder disease although the age group factor varies from epidemic to epidemic. The disease presents a paradox as regards its epidemiology, for as typhoid fever disappears, polio appears. In the past four or five years, with the eradication of the enteric diseases in Egypt, epidemics of polio have reappeared. Thus, we have come full circle. Polio was known to the ancient Egyptians.

The epidemiology is undergoing radical change owing to the Salk vaccine. For example: In the United States, January-September, 1955 there had been 23,000 cases; January-September, 1956, 12,000 cases; and up to September of 1958, 2,400 cases of polio, an incidence of 0.1 that of peak years.

SYMPTOMS:

Minor: Fever, restlessness, headache, anorexia and vomiting, pain, hyperesthesia, paresthesia, stiffness and weakness.

Major: All of these PLUS actual paralysis.

SIGNS: Stiff neck, tripod sign, diminished deep tendon reflexes and muscle weakness.

Presumptive diagnosis is made by the lumbar puncture. Characteristic findings are polymorphonuclear leucocytosis shifting after 24 hours to a

lymphocytosis. The cell count can vary from 10-20 up to several hundred—even 1,000 and there will be a concomitant increase in the protein level. The chloride and the sugar levels are not of help in diagnosis except to exclude meningitis. Definitive diagnosis is made by virus studies of throat, blood, stool, and spinal fluid, and additionally, antibody titers can be determined. Blood should be drawn at the time of the acute disease and 4 to 6 weeks later for comparison.

DIFFERENTIAL DIAGNOSIS: One of the diseases that can closely resemble poliomyelitis is the Guillain-Barre syndrome (Landry's ascending paralysis; polyneuronitis). This is usually a paralytic disease, differentiated from poliomyelitis by its more gradual onset and by involvement of the sensory, as well as the motor system. There may be high protein in the cerebrospinal fluid without cells, the so-called albumino-cytologic dissociation. Although the amount of recovery to be expected is considerably more than in polio, these cases don't always recover completely. Generally, Guillain-Barre exhibits centripetal return of function; the hands and feet recovering last. A recently reported case of special interest concerned a veteran who was given an injection of unmodified tetanus anti-serum, (he probably should have been given tetanus toxoid because an antibody response would be anticipated even ten years after his service-given toxoid immunization.) He developed typical serum sickness with fever, restlessness, joint pain, followed by ascending paralysis which finally involved the muscles of respiration. He was put in the tank respirator but was rapidly getting worse. He then was given cortisone with dramatic relief in 48 hours. Antibodies to horse serum were subsequently shown to be present in blood and spinal fluid. This apparently was a Guillain-Barre syndrome with an antigen-antibody reaction in which the central nervous system was the shock organ. A second similar case was seen in Youngstown in August, 1958.

The differential diagnosis between poliomyelitis and encephalitis should not be too difficult, as there is usually no accompanying paralysis in the latter. Meningitis and even rheumatic fever have been confused with poliomyelitis, and infants with painful subperiosteal hemorrhages of scurvy may lie immobile in a face down position that may be confused with paralysis.

A severe polio-like picture with paralysis may be seen when a patient has a dual infection with either two Coxsackie viruses or one Coxsackie and one ECHO virus. Fortunately this is a rare occurence.

TABLE I— CLINICAL TYPES OF POLIOMYELITIS WITH REGION OF NEUROLOGIC INVOLVEMENT AND SUGGESTIONS FOR TREATMENT

Type	*Cord Region Involved*	*Clinical Manifestation*	*Special Treatment*
Encephalitic	Motor Cortex (Rare) Cerebellum (Rare) Cranial Nerves	Spastic paralysis Ataxia	
Bulbar	Cranial Nerves IX, X and XII	Pharyngeal paralysis inability to swallow and handle secretions	Tracheotomy-(particularly mandatory in children)
	Medullary Centers for Respiration and Circulation	Irregular, shallow or Cheyne-Stokes Respiration Tachycardia	Respirator if ventilation inadequate and V.C. « 1.2 Liter

Type	*Cord Region Involved*	*Clinical Manifestation*	*Special Treatment*
Bulbar Plus High Spinal			Usually a tracheotomy AND respirator
High Spinal	Cervical region especially C3, 4 and 5 T 1-10	Hyperthermia Diaphragmatic and Intercostal paralysis	Respirator if V.C. « 1.2 Liter, Adult V.C. « 0.5 Liter, Child or any cyanosis
Spinal	Extremity and trunk Segments of cord	Extremity and trunk paralysis	Physical therapy and re-education

Bulbar polio should be sharply differentiated from high-spinal polio. This is sometimes not done, an error than can lead to death. Bulbar polio involves the respiratory and circulatory centers resulting in tachycardias, bradycardias, cardiac irregularities, or irregular, shallow respirations, Cheyne-Stokes, Biot breathing and so forth. There is no specific treatment for this unless respiration or circulation fail. Drugs are used for bradycardia, sponging for hyperpyrexia. If the 9th, 10th, or 12th cranial nerves are involved so that the pharynx collapses or the tongue falls back in the mouth, then aspiration or obstruction to the airway can result. One of the earlier signs of bulbar involvement with pharyngeal and palatine paralysis is regurgitation of water through the nose.

Bulbar cases can get into trouble in one of several ways: The centers can go haywire, causing hyperthermia, irregular respiration or cardiac irregularities; pharyngeal paralysis can lead to obstruction to the airway; paralysis of the recurrent laryngeal nerve with resultant vocal cord paralysis will obstruct the larynx. For reasons as yet not clear hyperthermia is particularly prone to appear when the high cervical region is involved. Treatment of such paralysis includes discontinuance of oral feedings, positioning the patient in a 10-15° head-low position so that the secretions will puddle in the oral or nasal pharynx, and suctioning to keep the pharynx as clear of mucus as possible. Tracheotomy is indicated if secretions cannot be handled, particularly in children. The tracheotomy tube should be of good size, almost large enough to fill the entire lumen of the trachea. This prevents the aspiration of mouth secretions by the tugging action of the chest. If the airway is large the pressure gradient will not be great enough to cause aspiration of the secretions.

In the high-spinal disease, the paralyzed lower-motor neurons (T1-10) are those which innervate the muscles that pump the rib cage bellows. If the disease also affects the cervical region and especially C-3, 4, (and sometimes C-5), there is an associated paralysis of the diaphragm. Generally, total diaphragmatic paralysis is a more severe complication than total intercostal paralysis.

EARLY SIGNS OF HIGH SPINAL POLIO: When the vital capacity has dropped to 1,500 ml, a respirator should be standing by. Earlier signs of high spinal involvement include use of the accessory muscles of respiration, anxiety, restlessness, irregular or shallow respiration, shortness of breath, and a limited ability to count with one breath. From clinical experience, 30 ml of V. C. can be assigned for each number counted. Thus, if a patient counts to 30 with one breath the estimated vital capacity is 900 ml, a rough but useful clinical tool. Certainly, in adults, if the vital capacity falls below 1,200 ml the tank respirator is indicated. The corresponding limit is 500 ml in children.

RESPIRATORY AIDS: The tank respirator is the best mechanical ventilator because it encases the entire breathing bellows, allowing the chest to

expand in all directions as the pressure drops. The rib cage can move up and the diaphragm can descend because the abdomen can bulge. The Emerson tank is a little larger than the Drinker-Collins tank, and for that reason the patients are a little more comfortable in the former. The Cuirass Respirator (shell) is less efficient but allows the patient greater mobility and freedom permitting him better treatment and nursing care. The Rocking Bed is the least efficient of these three commonly used types, because it moves only the diaphragm. As the head of the bed is elevated the viscera, which are rather firmly attached to the diaphragm, draw the diaphragm down. As the head is lowered the abdominal contents, which have the weight and consistency of fluid, weigh the diaphragm down. Thus, the diaphragm behaves like a piston in a cylinder-like rib cage. The use of positive pressure directly to the mouth of the patient has been reported, (much like the Bennett intermittent positive pressure breathing device). Instead of the elaborate mouthpiece and noseclip, a pipestem mouthpiece is placed directly in the patient's mouth. This method permits a patient to change from one aid to another and to move about from place to place.

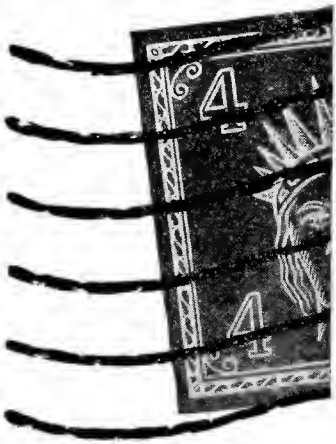
A combination of bulbar and high spinal polio will usually mean both a tracheotomy with round the clock nursing care and a tank respirator if patients, particularly children, are to be saved. A few stoic adults will have enough presence of mind to indicate when they need suctioning. Occasionally such adults can be placed in a tank respirator without a tracheotomy even though they have respiratory and pharyngeal paralysis. However, accidents can occur leading to aspiration, so if there is doubt, a tracheotomy and a tank should be used.

Thus far we have not considered cyanosis. To refer to cyanosis in poliomyelitis is like giving highway directions by saying that at a certain landmark one has already driven too far. If the patient has cyanosis then somewhere measures to relieve the respiratory paralysis or airway obstruction have not been utilized. Now it is almost too late and specific measures are urgently indicated.

SPINAL POLIO: This is the most common form of polio and involves areas of the cord exclusive of the respiratory or bulbar regions. Spinal polio actually may have associated high spinal involvement which may not be recognized clinically unless there is considerable respiratory weakness because of the large reserve of respiratory muscles. In spinal polio our attention is frequently directed toward the limb paralysis. However, trunk paralysis must not be overlooked.

PROGNOSIS: During the febrile stage the prognosis is in the balance. The paralysis can extend at any time until the patient has been afebrile 24 hours. In the early post-febrile period, because of extreme exhaustion, it may appear that the patient is totally paralyzed where as such is not the case. The "miraculous cures", occasionally reported, probably fall into this group. After a week or ten days the prognosis can be determined from the degree of paralysis present. An estimate of the amount of recovery likely to be achieved can be arrived at by anyone with experience in this disease. Those muscle groups still classified as zero, two weeks post-febrile, generally remain extremely weak, e. g. zero or trace. There is usually considerable recovery in functional muscle groups. Those areas that have fair to good muscle function at this time usually ultimately increase several grades.

THE TREATMENT OF POLIOMYELITIS: There is no specific therapeutic agent for poliomyelitis; sedation should be avoided, shock can be treated with norepinephrine, precautions should be taken against possiblity of aspira-



BRONCHIAL ASTHMA, Allergic rhinitis—(Male, age unknown), *Source:* M.D., California

"Asthma cleared and patient slept through whole night; sense of smell returned completely. Effect occurred within 12 hours of first dose."

POISON OAK DERMATITIS—(Male, 41), *Source:* M.D., Georgia

"Complete clearing of severe dermatitis."

SEVERE CHRONIC URTICARIA—(Female, 36), *Source:* M.D., Massachusetts

"Excellent results. No headache, mild increase in good spirits and appetite, no edema, no change in B. P."

BURSITIS OF BOTH SHOULDERS—(Female, 35), *Source:* M.D., Pennsylvania

"Improved after 1 dose (0.375 mg.). After first day slept well. No pain."

FROZEN SHOULDER SYNDROME—(Male, 64), *Source:* M.D., Indiana

"Patient had painful, tight shoulder with only minimal movement. After 48 hours, patient obtained approximately 50% return. In 6 days established 80% return of function followed by gradual return of usage."

RHEUMATOID ARTHRITIS and SPONDYLITIS—(Female, 67), *Source:* M.D., Louisiana

"Bedridden patient now returned to useful self again. Maintained on 0.75 mg. b.i.d."

CONTACT DERMATITIS—(Male, 21), *Source:* M.D., Missouri

"Itching relief in one day—rash gone in three days."

ASTHMA (Status)—(Female, 38), *Source:* M.D., Texas

"Patient completely relieved after 2nd dose of Deronil."

GIANT URTICARIA, ANGIONEUROTIC EDEMA (Recurrent following insect stings)—(Male, 10), *Source:* M.D., Tennessee

"Urticaria cleared after first 0.375 mg. dose, angioneurotic edema after second. No recurrence (to my knowledge) after Deronil discontinued."

HERPES ZOSTER—(Female, 41), *Source:* M.D., Nebraska

"No response from enzymatic therapy; relief from pain in 24 hours on Deronil. Lesions cleared in 8 days."

ERYTHEMA MULTIFORME—(Patient not identified), *Source:* M.D., Alabama

"I believe the addition of Deronil to the antibiotics and local treatment was of distinct value in this case."

*Response of patients to DERONIL as reported by physicians to the Schering Department of Professional Information.

Schering

Consult Schering literature for details of indications, dosage, precautions and contraindications.
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DERONIL—T.M.—brand of dexamethasone.

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tion, and congestive failure and pulmonary edema require appropriate treatment. The usual treatment for urinary bladder paralysis is insertion of an indwelling catheter but this can be easily forgotten and left overly long in place. The end result of such indwelling catheter neglect can be a large stag-horn calculus and chronic ineradicable infection. The probable sequence of events is as follows: The bladder is often paralyzed early; catherization will introduce bacteria into the lower, and frequently, the upper urinary tract; proteus organisms will split urea to make ammonia and an alkaline urine (nearly all other bacteria will spit urea to some extent). At the same time there is an out-pouring of calcium phosphate into the urine which reaches a peak at four to six weeks post-onset and is particularly heavy in young adults. Nine months to a year may be required before the body comes into equilibrium in an osteoporotic state. Thus, at the critical six week period the patient has an alkaline urine carrying large amounts of calcium phosphate, an extremely insoluble compound in an alkaline medium. The presence of bacteria and debris as potential nidi, further favor the production of calculi. We observed a calculus incidence of 60% among respirator patients. Stone formation can be prevented by high fluid intake (3 liters/day), maintenance of an acid urine with bacterial suppressing agents, and avoidance of stasis. Calcium binding in the gastrointestinal tract and chelation of calcium in the urine may also be helpful.

Other therapeutic measures are pretty much symptomatic; heat seems to relieve pain.

TREATMENT DURING THE LATER CONVALESCENT PHASE: Since patients can have myocarditis as evidenced by tachycardia and exhaustion, rest is extremely important. Also, it appears that muscles recover more slowly if they are overly used early. Injury to the patient should be prevented and one should guard against too early mobilization with consequent recurvatum of the knee, contractures or muscle injury. It is important to start gently administered physical therapy early in the course. When referring a patient for physical therapy, a prescription should be written. At first gentle passive exercises shold be prescribed progressing to active exercises and then active-resistive exercises. Passive exercises are useful early to regain the full range of motion because considerable shortening of involved muscles particularly hamstring and back occurs. Then active exercises are begun in which the patient takes the extremity through the normal range, and finally exercises against resistence are instituted. Shortened muscle groups should be stretched, though not too vigorously at first. Lower motor neuron paralysis affecting a large muscle belly is followed by atrophy. Therefore, stretching and exercising should be very gentle during the early weeks. Eventually these muscles will become fibrosed, organized and strong and will tend to shorten. These muscles should eventually be stretched to their normal length. At this time special aids may be introduced e.g., garments, leg braces and crutches. Investigation of the social and vocational aspects of the situation in adults is important. Physicians may eventually lose practice and prestige to other professions unless they show more interest in such "paramedical" problems.

IMMUNIZATION PROCEDURES: Passive immunization by means of gamma globulin is important for contacts in the house. Active immunization with the Salk vaccine is given in two injections one month apart followed by a booster in seven months. It is between 60 and 90% effective in preventing poliomyelitis. In some areas a fourth shot is being given. The Sabin vaccine is an avirulent live virus to be taken by mouth; the need for this vaccine is not yet clear. If the Salk vaccine is 90% effective, the disease will be eradi-

POSTGRADUATE
Warren--Wednesday, O
Sixth Councilor District--Ohio St

Speakers

B. K. Wiseman, M.D.
Professor of Medicine
Ohio State University
College of Medicine

Ralph F. Bowers, M.D.
Chief of Surgery
Kennedy Veterans Administration Hospital
Memphis, Tennessee

Henry Doubilet, M.D.
Associate Professor of Surgery
New York University
College of Medicine

H. E. MacMahon, M.D.
Professor of Pathology
Tufts University College of Medicine

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Associate Physician
Department of Pediatrics
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Detroit, Michigan

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Former Associate Surgeon
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College of Medicine

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Cleveland Clinic

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McGill University Faculty of Medicine

Joseph M. Hayman, Jr., M.D.
Dean--Professor of Medicine
Tufts University College of Medicine

George O. Eaton, M.D.
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Orthopedic Surgery
John Hopkins University
School of Medicine

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Western Reserve University

Edwin R. Levine, M.D.
Assistant Clinical Professor of Medicine
Chicago Medical School

Michael J. Brennan, M.D.
Director of Oncology
Henry Ford Hospital
Detroit, Michigan

David Doyle
New York City

Morning Ses

8:00		Regist
8:45-9:15		Cinecli Techni Hemor
9:30-10:40	Medical	Newer Agents Leuker Dr.
	Surgical	Diverti Dr. Dr. Dr.
	Pediatric	Parent Dr. Dr.
	Ob-Gyn	Menstr Empha Dr. Dr. Dr.
	Med.-Surg.	Periph Arteria Dr. Dr.
11:00-12:10	Medical & Surgical	Pancre Surgica Dr. Dr. Dr.
	Orthopedic	Fractur & Foot Dr. Dr.
	Pediatrics	Recurre Pain in Dr. Dr. Dr.
	Ob-Gyn	Incomp Dr. Dr. Dr.
12:10		Lunche

REGISTRATION 8:00 a.m., Wed., Oct. 21

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DUATE ASSEMBLY
esday, October 21, 1959
--Ohio State Medical Association

ning Sessions

	Registration	1:00-1:30
	Cineclinic Technique for Hemorrhoidectomy	1:45-2:45
Medical	Newer Chemotherapeutic Agents in Management of Leukemia & Lymphomas Dr. B. K. Wiseman	
urgical	Diverticulosis-Diverticulitis Dr. Ralph F. Bowers—moderator Dr. Henry Doubilet Dr. H. E. MacMahon	
ediatric	Parenteral Fluid Therapy Dr. Gordon Manson—moderator Dr. Nicholas M. Stahl	
b-Gyn	Menstrual Disorders with Emphasis on their Management Dr. S. Leon Israel—moderator Dr. Abraham F. Lash Dr. Edward C. Mann	
ed.-Surg.	Peripheral Vascular Disease Arterial Dr. Victor DeWolfe—moderator Dr. J. McCaughan	3:00-4:00
Medical Surgical	Pancreatitis—Medical and Surgical Aspects Dr. Henry Doubilet—moderator Dr. Ralph F. Bowers Dr. Charles H. Brown	
rthopedic	Fractures of Hand, Forearm & Foot Dr. Wallace Duncan—moderator Dr. Elden C. Weckesser	
ediatrics	Recurrent Vague Abdominal Pain in Childhood Dr. Nicholas M. Stahl—moderator Dr. Gordon Manson Dr. Ronald L. Denton	4:10-5:10
b-Gyn	Incompetent Cervical Os Dr. Abraham F. Lash—moderator Dr. S. Leon Israel Dr. Edward C. Mann	5:30-6:45
	Luncheon	7:00-9:00

Afternoon Sessions

	Cineclinic—Hospital Infections	
Medical	Problem of Pyelonephritis Dr. Joseph M. Hayman, Jr. Dr. H. E. MacMahon	
Pediatrics	Hyperbilirubinemia of the New Born Dr. Ronald L. Denton	
Orthopedic	Fractures of the Femoral Neck Dr. George O. Eaton	
Surgical	Peripheral Vascular Disease Venous Dr. John J. McCaughan—moderator Dr. Victor DeWolfe	
Ob-Gyn	Newer Concepts of Analgesia and Anesthesia in Ob-Gyn Dr. Robert A. Hingson—moderator Dr. Abraham F. Lash Dr. S. Leon Israel Dr. Edward C. Mann	
Medical	Failing Lung of Middle and Old Age Dr. Edwin R. Levine	3:00-4:00
Surgical	Hope for the Metastatic Carcinoma Patient Dr. Michael J. Brennan—moderator Dr. Ralph F. Bowers Dr. Nicholas M. Stahl	
Obstetrics and Pediatrics	The Complicated Pregnancy, Effect on Mother and Child Dr. Edward C. Mann—moderator Dr. Gordon Manson Dr. Ronald L. Denton Dr. S. Leon Israel Dr. Abraham F. Lash	
	Clinical Pathological Conference Dr. H. E. MacMahon—moderator Dr. Ralph F. Bowers Dr. Henry Doubilet Dr. B. K. Wiseman Dr. Joseph M. Hayman, Jr.	4:10-5:10
	Reception	5:30-6:45
	Banquet David Doyle—Speaker	7:00-9:00

Make advance registration checks payable to: Sixth Councilor District

Mail to: G. A. Sudimack, M.D., 342 Oak Knoll, N.E., Warren, Ohio.

cated. If the Salk vaccine should fail, then the Sabin vaccine might have a part to play. At the present time it is regarded as a laboratory tool. Concerning risk to the hospital personnel: In a study at the Baltimore City Hospital the usual isolation techniques apparently prevented transmission of the virus between patients and 50 suceptible hospital personnel. Investigators obtained titer levels on 50 susceptible individuals including nurses and house officers in May or June, before the annual epidemic period. At the end of the polio season they examined these same 50 people none of whom had an appreciable rise in titer to the virus. The usual precautions, masks, gowns, washing hands and proper disposal of excreta were considered adequate.

COMPLICATIONS OF POLIO: Atelectasis occurs as a consequence of weak cough when the diaphragm, intercostals or abdominal muscles are palayzed. Cough is the watchdog of the lung, a physiologic process, and if not effective secretions cannot be carried away and the result is atelectasis. This complication may masquerade as "pneumonia" or if patchy and segmental, go unrecognized producing only a low-grade fever. Generally speaking, a patient with respiratory muscle weakness who shows a triangular density associated with fever should be considered to have atelectasis until proven otherwise.

Failure of the patient's temperature to return to normal after 1 or 2 days of what is diagnosed as upper respiratory infection may be the first sign of this complication. A little twinge of chest pain and the complaint of increased mucus are enough to justify roentgenographic studies in respiatory poliomyelitis. This complication is particularly prone to occur during the late stages of an upper respiratory infection when the secretions become thick and stringy. Of course pneumonia and lung abcess can occur.

Patients may be aided with their cough by manually pressing over the upper abdomen and lower rib cage, by mechanical cough devises, use of suction, bronchodilators, detergents such as Alevaire, frequent changes of position and early use of antibiotics after cultures have been obtained. Failure to respond clinically or roentgenographically to the above measures is indication for bronchoscopy.

TABLE II— COMPLICATIONS OF POLIOMYELITIS

Atelectasis	Ruptured appendix
Pneumonia and Lung abscess	Congestive heart failure
Emphysema	Myocarditis
Intratracheal bleeding and trauma from sharp, long or ill-fitting trach tubes	Pulmonary edema
Intratracheal polyp	Hypertension
Pneumothorax	Pyelonephritis, calculi and calcinosis
Hyaline membrane	Hypoventilation syndrome
Bronchiectasis and lipoid pneumonia	Hypoventilation syndrome; anoxia, etc.
Thrombophlebitis with pulmonary emboli	Emaciation and malnutrition
Purulent sinusitis	Altered emotional responses (hypothalamus)
Gastric and esophageal ulceration	Polycythemia
Gastric dilatation	Scoliosis and skeletal deformities

Atelectasis must also be guarded against when surgery becomes necessary. Precautions include adequate ventilation before and after surgery particularly when the patient is under the influence of respiratory-depressant drugs. Over-sedation must be avoided. Belladonna derivatives, usually con-

traindicated in poliomyelitis, should be used to avoid the excessive secretions accompanying anesthesia. Post-anesthetic emesis is a serious complication for a respirator patient without a cough reflex, and necessitates the avoidance of ether and its derivatives. Endotracheal anesthesia has been found safe though in general the type of anesthesia is not of paramount importance. Following surgery the tank respirator, frequent suctioning and mechanical cough devices have proved helpful.

Localized emphysema can occur particularly in patients who are in respirators. There is evidence that as portions of the lung are splinted, other areas, particularly anteriorly, are hyperventilated. Pneumothorax has occurred following rupture of an emphysematous bleb. Tension pneumothorax, an acute threat to life, demands immediate decompression. Intratracheal bleeding can occur from sharp, overly long or ill-fitting tracheotomy tubes. Intratracheal polyps have occurred after prolonged use of a tracheotomy tube. Pulmonary edema can occur with and without left heart failure. In the event of heart failure, one tool for decreasing venous return is to increase the positive airway pressure by increasing the negative pressure in the tank, thus damming venous return. Digitalis can be used. Hypertension seems to occur when medullary centers are involved or chronic anoxia exists.

Pyelonephritis follows stasis, bladder infection and calculus formation. The hypoventilation syndrome is of interest. Patients in a tank respirator may become acclimated to an excessive tidal ventilation easily tolerating such overventilation. When taken out of the respirator to breathe spontaneously they will hypoventilate because of weakness or fatigue. Although their minute volume would under normal circumstances be adequate, the relative hypoventilation is accompanied by a sharp shift in pH, a situation that can not be long tolerated, and the patient will soon ask for the respirator. This becomes a habituation problem.

Complete anorexia with malnutrition and emaciation occurs in patients who have involvement of the base of the brain. Altered emotional responses are noted in the presence of hypothalamus lesions. Psychologically loaded feelings that may remain as residue of poliomyelitis include feelings of guilt e. g., "I must have done something terrible to make this happen to me." This may be inadvertently emphasized by bedside discussion about the effects of exercise during the prodromal period upon the ultimate extent of paralysis. Patients may show changes in personality, lability of mood, and depression with phobic and anxiety features.

Patients may develop polycythemia which can lead to right heart failure. Hypoxia resulting from the inadequate ventilation leads to adjustments similar to those made by subjects living at high altitudes, partially at least compensating for the decreased ventilation. Intermittent mechanical ventilatory aids in the unassisted patient or increased use of these aids by those requiring assistance will result in recovery.

Excessively rapid weaning from respiratory aids can lead to complications presumably on the basis of slight but cumulative anoxia (hypoventilation syndrome) despite what seem to be normal tidal air flow and CO_2 elimination. In our experience slight restlessness may be the initial finding in anoxia. Other symptoms ascribed are tightness of soft tissues with limitation of joint mobility, gradually increasing hypertension, acne or seborrhea, "moon face," irritability, disinterest, depression, lability of mood with frequent crying spells and cutaneous or deep hyperalgesia. Other findings described by Lewis include hypercalcemia and hypercalcinuria, hyposthenuria, inanition, pulmonary hypertension and ultimately, renal or cardiac failure. Recognition and

application of proper ventilatory aids will result in reversal of the syndrome.

Hyaline membrane in the lung has been reported; bronchiectasis and lipoid pneumonia occur. Thrombophlebitis may be seen in patients immobilized over long periods and pulmonary emboli do occur; purulent sinusitis has occurred when patients are tube fed over prolonged periods of time. Gastric and esophageal ulcerations occur. A ruptured appendix and death occurrred when a patient failed to develop a board-hard abdomen, spasm, or rebound owing to paralyzed abdominal muscles and had therefore no indications of an acute intra-abdominal lesion. Gastric dilatation is an acute problem which can be relieved in a few minutes by naso-gastric intubation. Myocarditis can occur.

—*William D. Loeser, M.D.*

MEDICAL ADVISORY BOARD APPOINTMENT

Dr. Jack Malkoff has been recently appointed to the Medical Advisory Board of the United Cerebral Palsy Association of Youngstown and Mahoning County.

SOCIAL NEWS
St. Elizabeth Hospital

Dr. and Mrs. Raymond Boniface have just recently returned from a trip to France and Italy. I was assured that it was most worth while and decidedly therapeutic!

Congratulations to Dr. and Mrs. L. O. Gregg, our Editor-in-Chief, who have just moved into their new home on Whipporwill Lane along with their two daughters and new son.

Dr. and Mrs. R. Bruchs recently entertained a group of friends on their new patio. A most novel party, enjoyed by all.

Dr. and Mrs. Lowendorf were abroad recently and he is back to work filled with stories of the old countries.

Dr. and Mrs. Louis Zeller were recently in New York City catching up on sleep, eating and the latest plays.

Dr. and Mrs. John Hyland are now esconsed in their North side home with the new baby. Which brings to mind, Dr. and Mrs. Newsome are expecting not one, but two, storks in the near future.

Dr. J. B. Kupec took his son fishing recently before his son begins his new semester at Western Reserve.

Better-late-than-never Dept.: Dr. J. Kalfas was in Mexico recently and took the entire family along on the trip.

Congratulations to Dr. and Mrs. Caccamo on their new arrival recently.

Football is here and many of the men will be off hither and yon to see their favorites in action. However, at the last and first Youngstown University game there were many in attendance from both Staffs.

St. Elizabeth Staff men in evidence were J. Kalfas, Ed Pichette, Joe Newsome, John Hyland, Les Gregg, Wm. Evans, Elmer Wenaas, Gene Fry and Dave Levy. Those present but not mentioned, my apologies, but I too was watching the game. Of course. the indomitable John Stotler with Mike Vulista were "benched" in plain view.

Can't compete with Esther Hamilton but, W. O. and Mrs. Mermis are on their way to a trip to end all trips. I heard they were in Chicago for a couple of days to meet the other members of this fabulous tour.

Dr. J. J. Sofranec was away over the weekend returning his daughter to school.

A. Calder, M.D.

PHYSICIAN IN THE COMMUNITY

In his Presidential Address at the 40th Annual Convocation of The American College of Physicians on April 22, 1959, Dr. Dwight L. Wilbur discussed the future of the practice of medicine and the problems facing practicing physicians, with which all of us are familiar: "Third persons outside and inside the profession, health insurance, government and medicine, labor unions, the press, the law, and the pharmaceutical manufacturers."

He offers some answers and advice, a portion of which follows: "In the struggle to remain as independent as possible in the practice of medicine, to render high quality of care, to nurture good patient-physician relationship and yet to keep up with changing economic and social conditions, the physician must maintain a constant state of vigilance. He must understand and participate in and lead in the community and social order in which he lives, as well as in the medical science in which he is specifically trained. For to him to go to sleep either in the field of medicine or in the social developments in his community will cause him some day to waken abruptly, as did Rip Van Winkle, unknown and out of touch and sympathy with the times."

Later Dr. Wilbur states " . . . physicians must assume leadership as citizens in the community in which they live and in state and national affairs. They should also participate and assume leadership in local civic and private organizations, in chambers of commerce, local governments, Community Chests and united crusades, and in voluntary health agencies."

With this rather lengthy preamble I would like to urge each member of the Mahoning County Medical Society to do some serious thinking about his pledge to the 1960 Community Chest campaign. Many of our number have always contributed generously and conscientiously, some even sacrificially, some of us do nearly as well, some of us make a token $5.00 or $10.00 contribution, some of us contribute nothing.

In trying to arrive at a sum that we can and ought to give, perhaps a realization of what our fellow physicians are giving will help. In the 1957-1958 campaign, 206 physicians contributed a total of $14,235, 62 contributed nothing. In 1958-1959, 224 physicians contributed $14,804, and only 29 gave nothing. This last year, the average gift was $66.09. The maximum was $400.00, and the minimum was $5.00.

This community has been good to most of us. Perhaps we feel that our relatively good position as far as income, prestige, etc., is due entirely to our hard work and intelligence, and that we owe nothing to the community, particularly the less fortunate among us. We may also grumble that we do a lot of "charity work" for which we don't get paid, or that the Community Chest is geared only to take care of people that don't need to be taken care of, or that there are characters who are too lazy to provide care for themselves, and that it is too much like a "welfare state" of affairs. One other argument that is often heard is that "I give to my church so I don't feel the necessity to do anything else," or that "I have contributed to the hospital fund drive, etc."

Consciously or subconsciously we can think of arguments like this when actually we may be more concerned about protecting our pocketbooks than anything else.

The best answer to these arguments is a quick glance over the past few years of individual contributions of physicians. In general, those who do the most for their hospitals in teaching house officers and nurses, take responsibility in hospital fund drives and improvements, church activities and financial responsibilities in their churches, and spend a large amount of time in

voluntary health agencies, are the same ones who give the most generously to the Community Chest.

They seem to have a deeper sense of responsibility for the needs of our community. About the "welfare state" type of thinking, probably no refutation is needed. However, it should be mentioned that we complain about government (particularly federal) interference in our problems, and here is a strictly local home-grown and inspired attempt to handle social and economic problems, organized, run and paid for by our own community. We have no greater chance to show that problems which arise in this sphere can be handled locally without having ubiquitous Uncle Sam offer to do the job for us.

H. N. Bennett, M. D.
Chairman
Community Chest Committee

VOTE ON NOVEMBER 3

Before the next issue of the Bulletin comes off the press, you will know the name of the next Mayor of Youngstown. This, and other important offices are to be voted on at the November 3rd election. Don't forget to vote.

A card, distributed by the Better Government League of Youngstown, offers this potent thought "BAD POLITICIANS are elected by GOOD CITIZENS who don't vote."

PROCEEDINGS OF COUNCIL
Sept. 14, 1959

The regular monthly meeting of the Council of the Mahoning County Medical Society was held on Monday, Sept. 15, 1959 at the office of Dr. M. W. Neidus, 318 Fifth Ave., Youngstown, Ohio.

The following physicians were present: M. W. Neidus, President, presiding, H. P. McGregor, C. W. Stertzbach, C. E. Pichette, P. J. Mahar, F. G. Schlecht, M. S. Rosenblum, and Asher Randell.

Meeting was called to order at 9:10 p.m. The minutes of the previous meeting were read and approved.

Dr. Neidus read a letter from Mrs. Robert N. Gorman, Director of the Ohio Department of Public Welfare. Mrs. Gorman advised the Society that the department was making rules and regulations for all welfare programs and that there had been unavoidable delays in standardizing Aid for Aged payments throughout the state.

Dr. Schlecht reminded council that the Sixth District Postgraduate Day for 1960 would be in Youngstown. He named Dr. M. S. Rosenblum to the Postgraduate Day Committee for 1960.

Dr. Neidus passed around a letter from Sid Davis announcing his move from Youngstown. The motion was made, seconded, and duly passed that a resolution commending Sid Davis be sent to Mr. Davis and to WKBN.

Dr. McDonough read a resolution favoring social security for physicians, and asked if council wanted him to submit it at the next regular meeting of the House of Delegates of the Ohio State Medical Association. Following discussion, the motion was made, seconded, and duly passed that the resolution be submitted to the entire active membership of the Mahoning County Medical Society for a mail vote on whether it should be submitted to the Ohio State Medical Association. The executive secretary was instructed to mail out the ballot.

Dr. McGregor reported on the Canfield Fair. He announced that the

medical health exhibits were outstanding and that the medical health tent drew a record crowd. Dr. Stertzbach recommended that council send a letter to St. Elizabeth Hospital commending them on their exhibit. The recommendation was made that a letter from council be sent to Dr. McGregor commending him on his continued outstanding management of the annual medical health tent.

Dr. Reese brought up the question of the anesthesia clause in the Blue Cross contract. He pointed out that the clause states that Blue Cross will cover the cost of anesthesia where the hospital employee gives the anesthesia, and that the local hospitals no longer employ anesthetists. Therefore it might be desirable to change this clause in order not to mislead subscribers. It was suggested that the question be brought up at the September 22 meeting on insurance.

Dr. Neidus brought up the name of Dr. M. J. Sunday for Honorary Membership. Council voted in favor of this.

Dr. Neidus asked permission to call a special meeting of the Medical Society in October in order to submit the constitution to the membership. Council approved the meeting.

Dr. Neidus read a letter from the executive secretary requesting a raise in salary. Following discussion, the motion was made, seconded, and duly passed that the salary be raised.

Bills were read. A motion was made, seconded, and duly passed to pay each one. A list of the bills is attached to the minutes.

Meeting was adjourned.

F. G. Schlecht,
Acting Secretary

HAPPY BIRTHDAY!

Oct. 17
J. Malkoff
Oct. 19
L. C. Zeller
Oct. 20
U. A. Melaragno
H. Sisek
Oct. 23
J. E. L. Keyes
Oct. 24
H. E. Fusselman
Oct. 25
P. L. Jones
Oct. 26
J. H. Sloss
Oct. 28
I. H. Chevlen
M. M. Szucs
Oct. 29
F. K. Inui
Oct. 30
W. B. Turner
Nov. 3
D. R. Brody
Nov. 4
K. J. Hovanic
Nov. 6
L. O. Gregg
Nov. 9
J. B. Birch
Nov. 10
Samuel Tamarkin
Nov. 11
H. Schmid
Nov. 15
J. P. Kalfas
M. J. Colucci

PENICILLIN RESTRICTION LIFTED

The restriction of the Ohio Department of Health, in effect since Feb. 1, 1959, limiting patients over ten years of age, who are on a regime of rheumatic fever prevention to intramuscular penicillin, has been cancelled and is no longer in force.

In the future, a physician who has a patient on penicillin prophylaxis for the prevention of rheumatic fever may again order oral or intramuscular penicillin regardless of the patient's age.

Blanks for odering penicillin to be used in rheumatic fever prevention from the Ohio Department of Health are available from your local health department.

L. A. Blum, M.D.

FROM THE BULLETIN

Twenty Years Ago—October 1939

Three big events that month: the regular meeting where Dr. Louis Newburg of the University of Michigan spoke on "Diseases of Metabolism," the beginning of the fall lecture series with Dr. Charles Geschickter and the second Annual Dinner Dance. President Skipp said there were so many out-of-town meetings going on that a man would have no time to practice if he attended them all.

The depression was over and the State relief law had been changed so that medical relief was on the same footing as work relief. The County Commissioners were responsible for the care of the indigent sick at home but the Township Trustees were responsible for hospitalization. This situation was confusing.

Cards were sent out so that members could vote on changing the doctor's half-day from Thursday to Wednesday. They voted to change. Editor Patrick was concerned about the problem of juvenile delinquency and urged the establishment of special schools for retarded children.

There was a venereal clinic at the old Municipal Hospital on East Indianola Ave., treating 250 to 300 people a week. No Woodside Receiving Hospital those days.

D. A. Belinky, A. Rosapepe, Frederick S. Coombs and Vernon Leroy Goodwin were welcomed as new members.

The Mahoning Valley Tuberculosis Association was setting up a station for rapid X-ray screening of large groups of the population. The system was called collective fluorography. It was predicted that tuberculosis would gradually be banished as a health menace.

The Medical Crier said "Sometimes the money you spend foolishly is the best money you ever spent."

Ten Years Ago—October 1949

The first Diabetes Detection Drive was under way directed by a committee consisting of Morris Rosenblum, Arnoldus Goudsmit, Fred Coombs, W. S. Curtis, Herman Ipp, Robert Kiskaddon, Milton Yarmy, Harold Reese, Walter Tims, Elmer Wenaas, Howard Mathay, Pat Kennedy, John R. Buchanan and Gabriel DeCicco.

In an article outlining the purpose of the drive Dr. Goudsmit made some important statements: "1. No number of positive urine specimens ever makes a diagnosis of diabetes mellitus and no number of negative urines refutes it. 2. A fasting venous blood sugar above 120 mg. 100 cc. in the absence of complicating conditions is presumptive of diabetes; a fasting sugar over 140 mg. is practically conclusive. 3. A fasting blood sugar below 120 mg. per cent is compatible with the presence of a bona fide case of diabetes. 4. From the point of view of diabetes detection a single blood sugar determination after a meal is more informative than one taken in the fasting state."

St. Elizabeth's Hospital Staff announces the formation of a "Polio" team consisting of at least a pediatrician, physiotherapist and an orthopedist to care for poliomyelitis cases.

Raymond Catoline and Robert Jenkins were internes at the Youngstown Hospital. Dow Cushing was dental interne. Residents were F. A. Freidrich, R. A. Brown, J. L. Calvin, J. J. Campolito, R. R. Fisher, W. B. Hardin, F. K. Inui, F. E. Shaw, P. A. Dobson and J. R. Gillis. J. L. Finley was a fellow in Obstetrics.

At St. Elizabeth's Staff meeting R. B. Poling presided. Papers were

presented by W. T. Breesman and F. M. Lamprich. Dr. J. A. Renner described the use of the Cooney-Crosby button in liver cirrhosis with ascites. Sister M. Adelaide H.H.M. was announced as the new superintendent.

Dr. Harley Gibbs, Director of Industrial Medicine of the Carnegie-Illinois Steel Corporation addressed the Mahoning Academy of General Practice on "Chronic Lead Poisoning."

Sixth District Post-Graduate Day as announced for November with a group here from the Lahey Clinic. A. K. Phillips headed the Committee. Dr. Wm. Reinhoff was here from John Hopkins University to address the Staff of the Tuberculosis Sanitarium on "Treatment of Maligant Tumors of the Lungs."

It was a busy October.

J. L. Fisher, M.D.

MEDICAL GLEANINGS

PERIPHERAL NEUROPATHY IN MYXEDEMA

By Lamar E. Crevasse, M.D. and R. Bruce Logue, M.D., F.A.C.P., Atlanta, Georgia

Annals of Internal Medicine Vol. 50, No. 6, June, 1959

DISCUSSION

In myxedema there are diminished cerebral blood flow and cardiac output, and glucose utilization by the nervous system is altered. This profound alteration in metabolism is directly reflected in the nervous tissues, whose oxygen and glucose utilization and requirement are quite high. Consequently, the incidence of nervous system manifestations is exceedingly high. Lethargy, diminution of mental acuity and emotional disturbances are well recognized features of myxedema.

In patients with radioactive iodine-induced myxedema, we have investigated severe radicular type of pains in the upper and lower extremities by myelograms for herniated intervertebral discs, with negative findings. The character and distribution of the lancinating pains closely simulate pain of nerve root compression. Peripheral neuropathy, manifested by severe paresthesias and/or lancinating extremity pains, occurred in 47% of 65 patients with primary myxedema. It was the presenting complaint in three of this group. Histologic examination of a peripheral nerve in a patient with symptomatic myxedematous neuropathy has revealed swelling and degeneration of the myelin.

There is a specific action of the thyroid hormone at the myoneural junction, and this may account for the typical delayed reflexes and some of the neuromuscular weakness. Symptoms related to peripheral neuropathy are reversible, regardless of the duration of the illness, and will resolve on adequate thyroid replacement alone. The motor and sensory symptoms are accompanied by a paucity of neurologic findings, and the patients are occasionally thought to be hysterical.

SOCIETY PLANS DIABETES WEEK

The Mahoning County Medical Society will conduct the annual Diabetes Week, Nov. 15-21. Society members will be asked to cooperate by giving diabetes tests in their offices, free of charge. Diabetes testing material and literature will be distributed by the Woman's Auxiliary. Highlight of the week will be the Diabetes Meeting on Nov. 17. Chairman for this year's campaign is Dr. Milton M. Yarmy.

DR. GOLDBERG ELECTED

Dr. S. D. Goldberg was elected chairman of the Ex-Intern-Resident Association of St. Elizabeth Hospital at a recent Ex-Interns Day reunion. He succeeds Dr. Francis J. Gambrel.

Other officers include Dr. James K. Herald, Dr. Alex K. Phillips, Dr. J. J. Wasilko, Dr. L. O. Gregg and Dr. R. J. Sheetz.

One hundred and thirty-five doctors attended the reunion.

WOMAN'S AUXILIARY NEWS

The Woman's Auxiliary to the Mahoning County Medical Society met September 22 at the home of Mrs. John Noll. Following dessert and coffee new members were introduced.

Mrs. Arnoldus Goudsmit, program chairman for the meeting, introduced the following panel members for a discussion of Paramedical Careers:

Dr. A. E. Rappoport, pathologist, Director of Laboratories, Youngstown Hospital.

Dr. Ivan C. Smith, specialist in physical medicine.

Mrs. Jean H. Phillips, Personnel Director, St. Elizabeth Hospital.

Miss Marie Kryzan, teacher in social studies and guidance departments, Rayen School.

Due to the amount of time available and the breadth of the subject, careers of nurses, dieticians, psychologists, pharmacists, midwives, anesthesia technicians and others requiring an M.D. or PhD. were not discussed.

Dr. Rappoport outlined the training of Medical Technologists with the emphasis on educational requirements and specialized training schools.

Dr. Smith explained the work of both physical and occupational therepists and the training they require. The in-service training of X-ray technicians was mentioned.

Mrs. Phillips emphasized the growing need of Administrative personnel within the hospitals such as medical secretaries, medical social workers, medical record librarians and technicians, hospital administrators and general clerical workers.

How young people become interested in these paramedical careers was illustrated by Miss Kryzan. Through the schools, guidance programs, both educational and vocational, are available. The community can help young people become interested in these careers through literature; sponsoring of "career days" during which students can become acquainted with the various fields; and adequate parental education to know what is available in the community and surrounding areas. Scholarships are available on the local, state, and national levels which can give financial assistance to students.

Serving on the program committee and assisting Mrs. Goudsmit was Mrs. John J. McDonough. The chairman of the social committee was Mrs. Frank G. Kravec assisted by Mrs. J. Allen Altdoerffer, Mrs. Lawrence Weller and Mrs. Henry Sisek.

Mrs. A. E. Rappoport, Mrs. Arnoldus Goudsmit and Mrs. W. H. Evans recently returned for the Fall Conference of the Ohio State Medical Auxiliary which was held at Lincoln Lodge in Columbus.

The Sixth District Meeting will be held in Warren on October 21st.

Mrs. Paul E. Ruth
Publicity Chairman

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